Safe pathways, systems and transitions

Score: 2

2 - Evidence shows some shortfalls

What people expect

When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place. I feel safe and am supported to understand and manage any risks.

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The local authority commitment

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Key findings for this quality statement

Safety management

The local authority had some understanding of the risks to people across their care journey. There were positive examples of working with health partners and other organisations to ensure systems kept people safe during transitions. There was a draft process in place using a prioritisation tool to manage risk to people awaiting assessment. This process was still to be finalised, the impact in some areas such as safeguarding was relatively recent in the past 6 months. The out of hours team (careline), utilised a risk management system which senior management felt proud of as the team constantly monitored risk against each contact/referral that was made to Careline. Staff told us that the availability of senior managers, practitioners and social workers made it easier to discuss complex assessments and risks which supported them in their decision making.

Safety during transitions

Staff told us that the preparing for adulthood team had been able to manage any negative impact on waiting lists due to their early access to preparing for adulthood team working with young people from the age of 14. Staff told us that they managed waiting lists for referrals for adult's psychologists with good risk management through the continued use of child's psychologist until they were seen by the adult's psychologist team.

The local authority had protocols in place to commence planning from the age of 14 onwards to support transition. However, we received mixed feedback about the transitions of young people. Partners told us that the transition from children's to adult service provision was not always a smooth process as services for young people are more bespoke than adults service provision. It was felt that some people at the age of 18 had no support in place, for others an assessment had been completed, however, their needs were not met. Carers felt the transition process was uninformed, frustrating and difficult to understand, which often left them to chase a lot of progress.

The integrated hospital discharge team worked effectively to ensure that there were safe transitions for people moving out of hospital, examples were provided of early identification of support by working with short term wards such as A&E, this was a way of preventing people from becoming admitted to hospital and getting people home swiftly. People told us that they felt safe with the support and services they had received and had felt involved in the whole process.

There were mixed responses on how effective co-ordination across different providers and services worked. Providers felt the local authority did not always work with them to ensure people received coordinated safe support when moving between different services.

Contingency planning

The local authority had in place contingency plans to ensure they were prepared for possible risks in provision of care and support. Policies stipulate a number of potential options in the event of provider failure including spot purchasing from other care providers or utilising temporary staff from local agencies.
